

Name: _____

Medicare #: _____

Birth Date: _____

Effective Date Hospital A: _____

Effective Date Medical B: _____

**** The information above can be found on your**

Address: _____

Zip Code: _____

Phone: _____



The state helps pay Medicare costs (Premiums, deductibles, and/or co-insurance)? ☐ Yes ☐ No

Pharmacy – 1st Choice: _____

If you are interested in exploring another Pharmacy for a Cost Comparison, please list:

[illegible]